Dr. Louis C. Pettit said he thought Dr. Hirsch had drawn the line too broadly in giving paranoia such a prominent place among individuals in general life. Many persons, doubtless, were eccentric, but we could scarcely call them paranoiacs.

Dr. Pettit said that the number of paranoiacs received at the State Hospital with which he was connected was not large. He had seen the disease develop during the secondary stage of syphilis. It might be due to an organic disease, and he recalled one case that developed late in life in a man with advanced arteriosclerosis. In its development it was not unlike some cases of dementia præcox. He did not agree with the statement that it was always an intellectual process at the onset but said that in the majority of cases there was primarily some sense deception in the various special fields, and cited instances of noted paranoiacs exhibited at the clinics, showing hallucinations in the fields of general sensation, taste and hearing; that ideation was affected through these more frequently than through the emotions and internal feelings. He also recalled cases where manic-depressive symptoms and other affective disorders developed during the course of paranoiac conditions. Very few of the cases he had seen deteriorated mentally.

Dr. B. Onuf said he agreed in the main with the views of Dr. Hirsch. He believed that true paranoia was a disease with which the patient was born, and consisted primarily in a wrong method of thinking, and required a certain degree of mental development before it could properly manifest itself. It might also, perhaps, remain latent, in the same manner that certain disturbances of ocular refraction remained latent until some particular condition brought them to light The faulty process of thinking was the essential feature of paranoia. The variations of the disease were dependent on the special attributes of the individual, and had no direct bearing on the disease itself. Their development depended on the degree of intelligence and other individual factors. Kraepelin, who had studied paranoia among the Japanese, noted the rudimentary character of the delusions among those people. In paranoia, hallucinations might be either present or absent, and they were usually the result of external stimuli or of very strong emotional influences. Auditory hallucinations, when present,—and they are the most frequent ones in paranoia—simply represent the thoughts of the patient which have become loud. It might at times be very difficult to distinguish paranoia from paranoid conditions, for example, dementia præcox. It might also be difficult to distinguish the alcoholic paranoiac from true paranoia, especially in those cases where the paranoia simply manifested itself through the abuse of alcohol. In distinguishing between these conditions, we should bear in mind that in alcoholism the hallucinations were apt to be primary, and the delusions built upon them, whereas in paranoia we had just the opposite; namely, the delusions were primary and the hallucinations secondary.

REPORT OF A CASE OF BRAIN TUMOR, WITH AUTOPSY

By Dr. Morris J. Karpas

The patient was a married woman, 44 years old, who was admitted to the Manhattan State Hospital on August 20, 1907. Her family history was negative and her previous history unimportant. As far as could be determined. the first evidences of her malady became manifest in 1904, when she began to have convulsive seizures which varied in frequency and intensity. At first they appeared once a week, and later she would have them several times a day. For the past three years she suffered with headaches, and was often troubled with emesis. It was also noticed that she became seclusive and somewhat cranky, and would frequently make peculiar remarks to her husband. In November, 1906, the symptoms of her disease became aggravated. She commenced to talk in a bizarre manner, her speech became affected and the convulsions were more frequent. She was unable to find proper words for the expression of her thoughts. She could not name objects, but identified them correctly when their names were suggested to her. She lost her ability to read or write French and English. The vomiting became more frequent; the headaches more severe. Evidences of right-sided paralysis were observed in the early part of November 1906, and she gradually grew ataxic in gait and station.

When the patient was admitted to the hospital, an examination revealed the following: Slight facial asymmetry; left side of the face somewhat elongated, and its muscular contraction was apparently more active than the opposite side. Tongue protruded in the median line; grips equal; the left lower extremity was decidedly shorter than the right, and its general musculature was in a state of atrophy; this was probably due to an injury she had received in early childhood. Elbow, supinator and wrist reflexes were active. The knee jerks were unequal, but brisk. Ankle jerks were present; no ankle clonus; Babinski's reflex was present on the right side. Corneal reflexes were much diminished. Stereognosis was doubtful. Reaction to pin-pricks more marked on the left than on the right side. Distinct tenderness to percussion on the left side of the cranium. Internal strabismus of the left eye; pupils more equal; irregular in outline; reaction to light was sluggish, but accommodation reflex was good. A slight optic neuritis was subsequently demonstrated. According to Dr. Adolf Meyer, there was a suspicion of a right hemianopsia. Hearing was more acute on the left side. An examination of the cerebrospinal fluid revealed the presence of serum albumin and a moderate leucocytosis. Heart and lungs negative. No arterio-sclerosis. Blood pressure, 125. Mentally, the patient was quiet; she did not seem to recognize her new environment, and showed no acute depression. She showed peculiar awkwardness in handling objects, especially in the right hand. During the months of September and October, she remained drowsy, fatigued and somnolent, at times moaning as though in pain. On November 2 1907, she had a general convulsion, with coma; several hours later she had a second convulsion, and five hours after this death occurred from exhaustion.

Dr. G. Y. Rusk, who made the autopsy in the case reported by Dr. Karpas, gave a detailed account of the pathological findings. The left hemisphere of the brain was distinctly larger than the right, and on palpation one could roughly outline a solid mass, underlying the lower third of the left posterior central convolution, and extending upwards and backwards beneath the supra-marginal and angular gyri, then downwards to the point of separation of the parietal and occipital lobes, then inwards and forwards towards the uncus, where an irregular colored soft tumorous mass projected from the mesial end of the Sylvian fissure, compressing and causing considerable distortion of the left optic tract, and also compressing the third nerve. There was considerable distortion of the temporal lobe; the pons appeared flattened, and the cerebellum was also compressed. The limitations of the growth could not be made out macroscopically;

its center and apparent origin, however, lay in the region of the left amygdala, and from this point the growth infiltrated the remainder of the corpus striatum, the overlying island of Reil, the adjacent surface of the temporal lobe, the internal capsule, the thalamus, and apparently the centrum ovale. Macroscopically, the growth was a glioma, chiefly of the small-celled type.

Dr. Abrahamson, in discussing the case reported by Dr. Karpas, said that the tumor, growing, as it did, from within the brain instead of from the cortex, should have given some indication of its location from the characteristics of the convulsions.

Dr. Karpas, in reply to Dr. Abrahamson, said the physicians who had charge of the case did not have any opportunity to study the character of the convulsions. The only convulsion observed in the hospital occurred shortly before the patient's death, and that was general in character.

A CASE OF GLIOMA OF THE BRAIN

By Dr. I. Strauss

The case was one of glioma probably originating in the wall of the ventricle and infiltrating the meninges. This condition was first described by Klebs, and up to a few years ago was not thought to exist.[1] The symptoms in the case were largely those pointing to an internal hydrocephalus. There was marked exophthalmus, blindness and slight weakness of the left facial. As a rule, in these cases, the cranial nerves were not involved.

Dr. Sachs said the German writers, even those of recent date, referred to certain sarcomatous tumors, particularly those springing from the spinal meninges, as non-malignant. This was not in accordance with the view taken of them here.

Dr. Strauss, in reply to Dr. Sachs, said the tumor in this case was regarded as a glioma starting from the embryonic cells, and which, by its rapid growth, had taken on the evidences of malignancy.

STREPTOCOCCEMIA, WITH SEPTIC ENDOCARDITIS AND INFARCTS

By Dr. Strauss

The case was one of streptococcemia, with septic endocarditis and infarcts. The patient developed a flaccid paralysis of all extremities, and died in a state of coma two hours after the onset of the hemorrhage. The autopsy showed a very extensive hemorrhage of the brain, involving the surface of the island of Reil on one side, extending out through the Sylvian fissure to the under surface of the brain and then breaking through into the third and lateral ventricles. The hemorrhage was entirely sub-pial.

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[1] Schlesinger in his monograph on tumors does not mention such a case. Since then there have been about nine cases reported.